

CERTIFICATE OF DEATH

06639

Reg. Dist. No.

6645

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plum Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>County Hosp.</u>				d. STREET ADDRESS <u>Prince Frederick</u>			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Bayer</u> Last <u>Bayer</u>				4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2</u>		9. AGE (In years last birthday) yrs. <u>93</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Broom</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Boston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marion Harrod</u> Address <u>Plum Point</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Hip (Femur)</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>May 9 1958</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Plum Pt. Calvert Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>58</u> , to <u>May 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jeff</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick Md.</u>			
PHYSICIAN'S NAME (Type) <u>Page C. Jeff</u>				DATE SIGNED <u>6/1/58</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmund</u>		22d. LOCATION (City, town, or county) (State) <u>Sundeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.E. Sewell, Prince Fred, Md.</u>				24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John J. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1880</u></p>		<p>4. Age: <u>38</u></p>	
<p>5. Place of birth: <u>Massachusetts</u></p>		<p>6. Date of death: <u>Jan 20, 1918</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John J. Smith</u></p>	
<p>11. Date of registration: <u>Jan 22, 1918</u></p>		<p>12. Place of registration: <u>Boston</u></p>	
<p>13. Name of informant: <u>John J. Smith</u></p>		<p>14. Address of informant: <u>123 Main St, Boston</u></p>	
<p>15. Name of informant: <u>John J. Smith</u></p>		<p>16. Address of informant: <u>123 Main St, Boston</u></p>	
<p>17. Name of informant: <u>John J. Smith</u></p>		<p>18. Address of informant: <u>123 Main St, Boston</u></p>	
<p>19. Name of informant: <u>John J. Smith</u></p>		<p>20. Address of informant: <u>123 Main St, Boston</u></p>	
<p>21. Name of informant: <u>John J. Smith</u></p>		<p>22. Address of informant: <u>123 Main St, Boston</u></p>	
<p>23. Name of informant: <u>John J. Smith</u></p>		<p>24. Address of informant: <u>123 Main St, Boston</u></p>	
<p>25. Name of informant: <u>John J. Smith</u></p>		<p>26. Address of informant: <u>123 Main St, Boston</u></p>	
<p>27. Name of informant: <u>John J. Smith</u></p>		<p>28. Address of informant: <u>123 Main St, Boston</u></p>	
<p>29. Name of informant: <u>John J. Smith</u></p>		<p>30. Address of informant: <u>123 Main St, Boston</u></p>	
<p>31. Name of informant: <u>John J. Smith</u></p>		<p>32. Address of informant: <u>123 Main St, Boston</u></p>	
<p>33. Name of informant: <u>John J. Smith</u></p>		<p>34. Address of informant: <u>123 Main St, Boston</u></p>	
<p>35. Name of informant: <u>John J. Smith</u></p>		<p>36. Address of informant: <u>123 Main St, Boston</u></p>	
<p>37. Name of informant: <u>John J. Smith</u></p>		<p>38. Address of informant: <u>123 Main St, Boston</u></p>	
<p>39. Name of informant: <u>John J. Smith</u></p>		<p>40. Address of informant: <u>123 Main St, Boston</u></p>	
<p>41. Name of informant: <u>John J. Smith</u></p>		<p>42. Address of informant: <u>123 Main St, Boston</u></p>	
<p>43. Name of informant: <u>John J. Smith</u></p>		<p>44. Address of informant: <u>123 Main St, Boston</u></p>	
<p>45. Name of informant: <u>John J. Smith</u></p>		<p>46. Address of informant: <u>123 Main St, Boston</u></p>	
<p>47. Name of informant: <u>John J. Smith</u></p>		<p>48. Address of informant: <u>123 Main St, Boston</u></p>	
<p>49. Name of informant: <u>John J. Smith</u></p>		<p>50. Address of informant: <u>123 Main St, Boston</u></p>	
<p>51. Name of informant: <u>John J. Smith</u></p>		<p>52. Address of informant: <u>123 Main St, Boston</u></p>	
<p>53. Name of informant: <u>John J. Smith</u></p>		<p>54. Address of informant: <u>123 Main St, Boston</u></p>	
<p>55. Name of informant: <u>John J. Smith</u></p>		<p>56. Address of informant: <u>123 Main St, Boston</u></p>	
<p>57. Name of informant: <u>John J. Smith</u></p>		<p>58. Address of informant: <u>123 Main St, Boston</u></p>	
<p>59. Name of informant: <u>John J. Smith</u></p>		<p>60. Address of informant: <u>123 Main St, Boston</u></p>	
<p>61. Name of informant: <u>John J. Smith</u></p>		<p>62. Address of informant: <u>123 Main St, Boston</u></p>	
<p>63. Name of informant: <u>John J. Smith</u></p>		<p>64. Address of informant: <u>123 Main St, Boston</u></p>	
<p>65. Name of informant: <u>John J. Smith</u></p>		<p>66. Address of informant: <u>123 Main St, Boston</u></p>	
<p>67. Name of informant: <u>John J. Smith</u></p>		<p>68. Address of informant: <u>123 Main St, Boston</u></p>	
<p>69. Name of informant: <u>John J. Smith</u></p>		<p>70. Address of informant: <u>123 Main St, Boston</u></p>	
<p>71. Name of informant: <u>John J. Smith</u></p>		<p>72. Address of informant: <u>123 Main St, Boston</u></p>	
<p>73. Name of informant: <u>John J. Smith</u></p>		<p>74. Address of informant: <u>123 Main St, Boston</u></p>	
<p>75. Name of informant: <u>John J. Smith</u></p>		<p>76. Address of informant: <u>123 Main St, Boston</u></p>	
<p>77. Name of informant: <u>John J. Smith</u></p>		<p>78. Address of informant: <u>123 Main St, Boston</u></p>	
<p>79. Name of informant: <u>John J. Smith</u></p>		<p>80. Address of informant: <u>123 Main St, Boston</u></p>	
<p>81. Name of informant: <u>John J. Smith</u></p>		<p>82. Address of informant: <u>123 Main St, Boston</u></p>	
<p>83. Name of informant: <u>John J. Smith</u></p>		<p>84. Address of informant: <u>123 Main St, Boston</u></p>	
<p>85. Name of informant: <u>John J. Smith</u></p>		<p>86. Address of informant: <u>123 Main St, Boston</u></p>	
<p>87. Name of informant: <u>John J. Smith</u></p>		<p>88. Address of informant: <u>123 Main St, Boston</u></p>	
<p>89. Name of informant: <u>John J. Smith</u></p>		<p>90. Address of informant: <u>123 Main St, Boston</u></p>	
<p>91. Name of informant: <u>John J. Smith</u></p>		<p>92. Address of informant: <u>123 Main St, Boston</u></p>	
<p>93. Name of informant: <u>John J. Smith</u></p>		<p>94. Address of informant: <u>123 Main St, Boston</u></p>	
<p>95. Name of informant: <u>John J. Smith</u></p>		<p>96. Address of informant: <u>123 Main St, Boston</u></p>	
<p>97. Name of informant: <u>John J. Smith</u></p>		<p>98. Address of informant: <u>123 Main St, Boston</u></p>	
<p>99. Name of informant: <u>John J. Smith</u></p>		<p>100. Address of informant: <u>123 Main St, Boston</u></p>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646 CERTIFICATE OF DEATH

Reg. Dist. No.

06640

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leroy A. Brown</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/02</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR <u>1</u> MONTHS <u>10</u> DAYS <u>19</u> HOURS <u>58</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick Mason</u>	
11. BIRTHPLACE (State or foreign country) <u>Lower Marlboro MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barriett</u>		14. MOTHER'S MAIDEN NAME <u>Ella Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MD. Pauline V. Brown -</u>	
17. INFORMANT <u>MD.</u>		Address <u>Huntingtown, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular senile disease</u> <u>442X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute dilatation of heart</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1958</u> to <u>6/10/58</u> , that I last saw the deceased alive on <u>6/10/58</u> , and that death occurred at <u>7:34 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. <u>Cummings</u> ADDRESS (Street, city or town, state) <u>MD 6/12/58</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>H. W. Ward</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Plum Point Church</u>		22d. LOCATION (City, town, or county) (State) <u>Plum Point, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy E. Berry</u>		24a. REC'D BY REGISTRAR <u>MD.</u> DATE <u>JUN 16 '58</u>	
ADDRESS <u>Huntingtown, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6647 CERTIFICATE OF DEATH

Reg. Dist. No.

06641

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lenzer Middle Benjamin Last Cox				4. DATE OF DEATH Month June Day 18 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Walter Cox				14. MOTHER'S MAIDEN NAME Susan P. Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-36-6988		17. INFORMANT Mrs Lenzer Cox Address Huntingtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH about 46 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-16, 1958 to 6-18, 1958 , that I last saw the deceased alive on June 18, 1958 , and that death occurred at 8:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Page C. Jett				ADDRESS (Street, city or town, state) Prince Frederick DATE SIGNED 6/20/58			
PHYSICIAN'S NAME (Type) PAGE C. JETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-21-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Harmony		22d. LOCATION (City, town, or county) (State) Near Owings, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Hutchins ADDRESS Owings				24a. REC'D BY REGISTRAR DATE JUN 24 '58		24b. REGISTRAR'S SIGNATURE Al. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH 1941		PLACE OF DEATH HOME	
SEX FEMALE		RACE WHITE	
AGE 65		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH 1876		PLACE OF BIRTH BALTIMORE	
NAME OF DECEASED MARY J. SMITH		NAME OF PHYSICIAN DR. J. H. SMITH	
NAME OF FUNERAL HOME J. H. SMITH & SONS		NAME OF BURIAL PLACE GREENWICH CEMETERY	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF FUNERAL HOME J. H. SMITH	
SIGNATURE OF DECEASED MARY J. SMITH		SIGNATURE OF WITNESSES J. H. SMITH & SONS	
SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Sutton</u>		4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 69</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fisher</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Della Robinson, Huntingtown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> <u>442X</u> DUE TO <u>Old Colostomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been in bed a year</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <u>Cloring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Palmyra Holiness Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brown's Island Calvert Co - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Harkness & Son - Huntingtown, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>
		DATE <u>JUN 9 '58</u>	

6649

CERTIFICATE OF DEATH

Reg. Dist. No.

06643

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE Virginia Maryland b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b Newborn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 702 S. Fayette St.			
3. NAME OF DECEASED (Type or print) First Female Middle Infant Last Griffith				4. DATE OF DEATH Month June Day 22 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1958	9. AGE (In years last birthday) Newborn	IF UNDER 1 YEAR Months 5 Days 30	IF UNDER 24 HRS. Hours 30 Min 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Donald Griffith				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address 702 S. Fayette St., Alex., Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June 22, 1958 , to June 22, 1958 , that I last saw the deceased alive on June 22, 1958 and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Roberto de Villarreal</i>				ADDRESS (Street, city or town, state) St. Leonards, Maryland			
PHYSICIAN'S NAME (Type) Dr. Roberto de Villarreal				DATE SIGNED June 23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/58	22c. NAME OF CEMETERY OR CREMATORY Ivy Hill	22d. LOCATION (City, town, or county) Alexandria	(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Beverly Mounts</i>			ADDRESS P. O. Box 65	24a. REC'D BY REGISTRAR 26 '58	24b. REGISTRAR'S SIGNATURE <i>W. Beverly Mounts</i>		
Cunningham Funeral Home, Inc. Alexandria, Va.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6650

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lusby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carrie A. Grover</u>				4. DATE OF DEATH <u>6</u> Month <u>16</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James A. Webster</u>				14. MOTHER'S MAIDEN NAME <u>Alice M. Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Calvin W. Grover, Jr.</u> Address <u>Lusby Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead sitting at a table</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/16/58</u>			
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby - Calvert Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Inc</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>W. B. Beach</u>		24b. REGISTRAR'S SIGNATURE _____	

CERTIFICATE OF DEATH

Reg. Dist. No.

06645

6651

1. PLACE OF DEATH o. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> o. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. EVERETT HALL</u>				4. DATE OF DEATH Month Day Year <u>June 25 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6 11</u>		IF UNDER 24 HRS. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabot County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>218-12-7035</u>			
17. INFORMANT <u>Everett Hall - Barstow, Md.</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>6/25 1958</u> , to _____, 19____, that I last saw the deceased alive on <u>6/25 1958</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. J. Hall</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/27/58</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				<u>PRINCE FREDERICK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>June 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow, Cabot Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. Zarkner & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR <u>1</u>		24b. REGISTRAR'S SIGNATURE <u>1958</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06646

Reg. Dist. No.

6652

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George</i> First Middle Last <i>Harper</i>		4. DATE OF DEATH Month <i>6</i> Day <i>3</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 13,</i>
9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Samuel Harper</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hawkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular renal disease</i> DUE TO <i>Hypertension - Hemiplegia</i> Conditions, if any, which gave rise to immediate cause (b) <i>6 hrs</i> (c) <i>stroke</i> DUE TO <i>stroke</i> causing the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had a headacher fell in field, brought to hospital</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>P. 260/158</i>	
20c. TIME OF INJURY Month, Day, Year <i>10/5 - 6/3 1958</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home farm</i>		20f. (City or town) <i>Huntingtown</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6-7-58</i>		22b. DATE THEREOF <i>6-7-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>House of Pray</i>		22d. LOCATION (City, town, or county) <i>Prince Geo. Co. Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell</i>		ADDRESS <i>Prince Fred, Md</i>	
24a. REC'D BY REGISTRAR <i>June 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4423

101

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death	
6. Place of death		7. Cause of death		8. Manner of death		9. Signature of Medical Examiner		10. Signature of Coroner	
11. Signature of Physician		12. Signature of Nurse		13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Registrar	
16. Signature of Witness		17. Signature of Witness		18. Signature of Witness		19. Signature of Witness		20. Signature of Witness	
21. Signature of Witness		22. Signature of Witness		23. Signature of Witness		24. Signature of Witness		25. Signature of Witness	
26. Signature of Witness		27. Signature of Witness		28. Signature of Witness		29. Signature of Witness		30. Signature of Witness	
31. Signature of Witness		32. Signature of Witness		33. Signature of Witness		34. Signature of Witness		35. Signature of Witness	
36. Signature of Witness		37. Signature of Witness		38. Signature of Witness		39. Signature of Witness		40. Signature of Witness	
41. Signature of Witness		42. Signature of Witness		43. Signature of Witness		44. Signature of Witness		45. Signature of Witness	
46. Signature of Witness		47. Signature of Witness		48. Signature of Witness		49. Signature of Witness		50. Signature of Witness	
51. Signature of Witness		52. Signature of Witness		53. Signature of Witness		54. Signature of Witness		55. Signature of Witness	
56. Signature of Witness		57. Signature of Witness		58. Signature of Witness		59. Signature of Witness		60. Signature of Witness	
61. Signature of Witness		62. Signature of Witness		63. Signature of Witness		64. Signature of Witness		65. Signature of Witness	
66. Signature of Witness		67. Signature of Witness		68. Signature of Witness		69. Signature of Witness		70. Signature of Witness	
71. Signature of Witness		72. Signature of Witness		73. Signature of Witness		74. Signature of Witness		75. Signature of Witness	
76. Signature of Witness		77. Signature of Witness		78. Signature of Witness		79. Signature of Witness		80. Signature of Witness	
81. Signature of Witness		82. Signature of Witness		83. Signature of Witness		84. Signature of Witness		85. Signature of Witness	
86. Signature of Witness		87. Signature of Witness		88. Signature of Witness		89. Signature of Witness		90. Signature of Witness	
91. Signature of Witness		92. Signature of Witness		93. Signature of Witness		94. Signature of Witness		95. Signature of Witness	
96. Signature of Witness		97. Signature of Witness		98. Signature of Witness		99. Signature of Witness		100. Signature of Witness	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6653

CERTIFICATE OF DEATH

Reg. Dist. No. 06647

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>				c. LENGTH OF STAY IN 1b <i>4 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burmes Island</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT FRANKLIN HORSMON</i> First Middle Last				4. DATE OF DEATH <i>June 27 1958</i> Month Day Year			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 9, 1898</i>	
9. AGE (14 years lost birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fishing & Dopting</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waterman</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William G. Foreman</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Foreman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give way or dates of service)		16. SOCIAL SECURITY NO. <i>220-03-8000</i>		17. INFORMANT <i>Mrs Carlene Foreman - Lusby, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure -</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerotic heart disease</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 26 1958</i> to <i>June 27 1958</i> , that I last saw the deceased alive on <i>June 26 1958</i> and that death occurred at <i>5 P M</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>5 P M</i> DATE SIGNED <i>6/27/58</i>			
ACTUAL SIGNATURE <i>R. De V. Carrere</i> M.D.				PHYSICIAN'S NAME (Type) <i>R. DE VICARRERE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Burmes Island Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Harkness & Son - Mutual, Md.</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>JUL 1 58</i>		24b. REGISTRAR'S SIGNATURE <i>W. S. ...</i>	

CERTIFICATE OF DEATH

1955

DECEASED'S NAME (Last, first, middle) LAST, FIRST, MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PLACE OF BIRTH STATE, COUNTRY STATE, COUNTRY	
DATE OF BIRTH DAY, MONTH, YEAR DAY, MONTH, YEAR		PLACE OF BIRTH STREET, CITY, STATE, COUNTRY STREET, CITY, STATE, COUNTRY	
DATE OF DEATH DAY, MONTH, YEAR DAY, MONTH, YEAR		PLACE OF DEATH STREET, CITY, STATE, COUNTRY STREET, CITY, STATE, COUNTRY	
CAUSE OF DEATH (List all causes, beginning with immediate cause) IMMEDIATE CAUSE INTERMEDIATE CAUSE REMOTE CAUSE		MANNER OF DEATH NATURAL ACCIDENT SUICIDE HOMICIDE UNDETERMINED	
SIGNATURE OF PHYSICIAN NAME, ADDRESS, CITY, STATE, COUNTRY NAME, ADDRESS, CITY, STATE, COUNTRY		SIGNATURE OF REGISTRAR NAME, ADDRESS, CITY, STATE, COUNTRY NAME, ADDRESS, CITY, STATE, COUNTRY	
SIGNATURE OF DECEASED'S NEXT OF KIN NAME, ADDRESS, CITY, STATE, COUNTRY NAME, ADDRESS, CITY, STATE, COUNTRY		SIGNATURE OF WITNESS NAME, ADDRESS, CITY, STATE, COUNTRY NAME, ADDRESS, CITY, STATE, COUNTRY	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6634

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06648

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>3407 - 37th St. Columbia Manor</u>			
3. NAME OF DECEASED (Type or print) <u>Ronald</u> First <u>Francis</u> Middle <u>Jacobs</u> Last				4. DATE OF DEATH <u>June 14</u> Month <u>June</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/33</u>		9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u>24</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank W Jacobs</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u>		16. SOCIAL SECURITY NO. <u>577-42-6472</u>		17. INFORMANT <u>F. W. Jacobs</u> Address <u>Columbia Manor, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest fracture of skull</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident.</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto hittree</u>					
20c. TIME OF INJURY Month, Day, Year <u>6/12 1958</u> Hour <u>7:30</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>		20f. (City or town) <u>Park</u> (County) <u>Cal.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>G. J. Weems</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>G. J. Weems</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem. Pittston, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>1st Rainier</u>				24a. REC'D BY REGISTRAR <u>W. Beach</u> DATE <u>JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

—MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6655

Item 7 Film G231 7/18/58 ggl

Reg. Dist. No. 06649

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 261 Le. Bury 263		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Huntingtown	
3. NAME OF DECEASED (Type or print) First CHARLES Middle S. F. Last JONES		4. DATE OF DEATH Month June Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1890
9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 25 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY same	
11. BIRTHPLACE (State or foreign country) Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Mary Riggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 217368869	
17. INFORMANT Mrs. Lula Jones-Huntingtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage 330 X DUE TO Ruptured Berry Aneurysm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 6/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/58	22c. NAME OF CEMETERY OR CREMATORY Plum Point Church Cemetery	22d. LOCATION (City, town, or county) (State) Plum Point, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leroy E. Berry		24. REC'D BY REGISTRAR W. H. Beach	
ADDRESS Huntingtown, Md.		DATE JUL 1 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Jones	
Sex		Male	
Age		25	
Date of Birth		1880	
Place of Birth		Maryland	
Usual Residence		Baltimore, Md.	
Cause of Death		Unknown	
Manner of Death		Natural	
Signature of Medical Examiner		Paul F. Smith, M.D.	
Signature of Coroner		John F. Smith	
Signature of Registrar		John F. Smith	
Date		1/25/20	
Place		Baltimore, Md.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial-exemption or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06650

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Huntingtown Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>John</u> Middle <u>Lankford</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 1883</u> 9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Albert John Lankford</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Danernheim</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 434.4 DUE TO (b) <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Died at 8:40 PM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in Bathroom</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 Min</u> 8 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>W. H. Hines</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>	

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2
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6657

CERTIFICATE OF DEATH

06651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sunderland Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Moore</u> Last <u>Moore</u> 4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1958</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 6,</u> 9. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>Samuel Jones</u> 14. MOTHER'S MAIDEN NAME <u>Anniella Tasker</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Florence Johnson</u> Address <u>Sunderland</u>		
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V.R. disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>58</u> , to <u>6-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-3</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Md</u> DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-8, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>	22d. LOCATION (City, town, or county) (State) <u>Sunderland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> ADDRESS <u>Prince, Fred, Md</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUN 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>	
<p>4. DATE OF DEATH [Handwritten: 10/15/1918]</p>		<p>5. TIME OF DEATH [Handwritten: 10:00 AM]</p>		<p>6. PLACE OF DEATH [Handwritten: Home]</p>	
<p>7. OCCASION OF DEATH [Handwritten: Pneumonia]</p>		<p>8. CAUSE OF DEATH [Handwritten: Pneumonia]</p>		<p>9. MANNER OF DEATH [Handwritten: Natural]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Handwritten: J. Smith]</p>		<p>11. SIGNATURE OF WITNESS [Handwritten: J. Doe]</p>		<p>12. SIGNATURE OF DECEASED [Handwritten: J. Doe]</p>	
<p>13. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]</p>		<p>14. SIGNATURE OF CLERK [Handwritten: J. Doe]</p>		<p>15. SIGNATURE OF JURY [Handwritten: J. Doe]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Wash DC</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i> d. STREET ADDRESS <i>720 E. N.E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>David Lewis Munos</i> First Middle Last		4. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 9-1918</i>
9. AGE (In years last birthday) <i>39 yrs.</i>		10. IF UNDER 1 YEAR Months <i>39</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agriculture Dept. U. S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Taylor Spring Ill.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Sebastian Munos.</i>		14. MOTHER'S MAIDEN NAME <i>Mary Munos</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes. U. S. A. 11</i>		16. SOCIAL SECURITY NO. <i>720 E. St. N.E. Washington, D.C.</i>	
17. INFORMANT <i>Mary Munos</i>		Address <i>720 E. St. N.E. Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Swimming</i> DUE TO (c) <i>Had been swimming, came ashore and died</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been swimming, came ashore and died</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Had been swimming</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Calvert</i>	
20c. TIME OF INJURY Month, Day, Year <i>6/12/58</i> Hour <i>5</i> a.m. <i>6</i> p.m. <i>5</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>N. Beach Ches Bay Calvert Md</i>		20f. (City or town) (County) (State) <i>Calvert Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <i>E. Owens Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/12/58</i>		22b. DATE THEREOF <i>St Agnes Cem.</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hillsboro, Ill.</i>		22d. LOCATION (City, town, or county) (State) <i>Ill.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons</i>		24. REC'D BY REGISTRAR <i>300-4th St N.E. Wash D.C.</i>	
25. REGISTRAR'S SIGNATURE <i>11 58</i>		26. REGISTRAR'S SIGNATURE <i>11 58</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Basslow</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Basslow</u> d. STREET ADDRESS <u>Stallins</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gray</u> First <u>William</u> Middle <u>Stallins</u> Last <u>Stallins</u> 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1958</u>				5. SEX <u>7</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 24 1914</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>43</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. Cochran</u> 14. MOTHER'S MAIDEN NAME <u>Mamie Zoller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Louise Stallins Basslow</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO (b) <u>002x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Died at 1030 Ave</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has been sick over a year</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-28-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u> 22d. LOCATION (City, town, or county) (State) <u>Prince Frederick Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hutchins</u> ADDRESS <u>Dwings Md.</u> 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>JUL 1 '58</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral-director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX _____	
3. AGE _____		4. DATE OF DEATH _____	
5. PLACE OF DEATH _____		6. TIME OF DEATH _____	
7. OCCASION OF DEATH _____		8. CAUSE OF DEATH _____	
9. MANNER OF DEATH _____		10. SIGNATURE OF EXAMINER _____	
11. SIGNATURE OF REGISTRAR _____		12. SIGNATURE OF WITNESS _____	
13. SIGNATURE OF DECEASED _____		14. SIGNATURE OF NEXT OF KIN _____	
15. SIGNATURE OF SURGEON _____		16. SIGNATURE OF JURY _____	
17. SIGNATURE OF JURY _____		18. SIGNATURE OF JURY _____	
19. SIGNATURE OF JURY _____		20. SIGNATURE OF JURY _____	
21. SIGNATURE OF JURY _____		22. SIGNATURE OF JURY _____	
23. SIGNATURE OF JURY _____		24. SIGNATURE OF JURY _____	
25. SIGNATURE OF JURY _____		26. SIGNATURE OF JURY _____	
27. SIGNATURE OF JURY _____		28. SIGNATURE OF JURY _____	
29. SIGNATURE OF JURY _____		30. SIGNATURE OF JURY _____	
31. SIGNATURE OF JURY _____		32. SIGNATURE OF JURY _____	
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89. SIGNATURE OF JURY _____		90. SIGNATURE OF JURY _____	
91. SIGNATURE OF JURY _____		92. SIGNATURE OF JURY _____	
93. SIGNATURE OF JURY _____		94. SIGNATURE OF JURY _____	
95. SIGNATURE OF JURY _____		96. SIGNATURE OF JURY _____	
97. SIGNATURE OF JURY _____		98. SIGNATURE OF JURY _____	
99. SIGNATURE OF JURY _____		100. SIGNATURE OF JURY _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06654

6660

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luxby</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ray Leroy STINNETT</u>		4. DATE OF DEATH <u>June 9, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1916</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Stinnett</u>		14. MOTHER'S MAIDEN NAME <u>Mother's Douchy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-12-47N</u>	
17. INFORMANT <u>Ruth Dister - Solomons, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHIAL ASTHMA + EMPHYSEMA</u> DUE TO (c) <u>MYOCARDITIS (CHRONIC) + HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 10, 1958</u> , to <u>JUNE 9, 1958</u> , that I last saw the deceased alive on <u>JUNE 8, 1958</u> , and that death occurred at <u>4 p. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick 6/9/58</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 12, 1958</u>	<u>St. Paul's Cemetery</u>	<u>Prince Frederick, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackmeyer & Son - Mutual, Md</u>		24a. REC'D BY REGISTRAR DATE JUN 12 '58	
		24b. REGISTRAR'S SIGNATURE <u>Quelamich</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06655**

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avon Park</u> ✓ d. STREET ADDRESS <div style="text-align: right;">48X-3</div> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> ^{First} <u>W</u> ^{Middle} <u>Truman</u> ^{Last}			4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L. B. Road</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Augustus J. Truman</u>				
14. MOTHER'S MAIDEN NAME <u>Eliza Buffat</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>704-18-1536</u>			17. INFORMANT <u>Phyllis B. Gray Prince Frederick</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> DUE TO (b) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bedroom</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				
20a. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20e. (City or town)			20f. (County)				
20g. (State)			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE <u>H. W. Ward</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type)			DATE SIGNED <u>6/12/58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u>			24. REC'D BY REGISTRAR <u> </u>				
25. REGISTRAR'S SIGNATURE <u> </u>			26. DATE <u>June 16 '58</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 18

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH (If at home, give address)		DATE OF DEATH (Month, day, year)	
NAME OF DECEASED (Full name)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years, months, and days)		OCCUPATION (If deceased, give last occupation)	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		PLACE OF BIRTH (City, State, and Country)	
CAUSE OF DEATH (Immediate cause)		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
PREVIOUS ILLNESS (If any, describe)			
SIGNATURE OF MEDICAL EXAMINER (Print name and title)			
SIGNATURE OF WITNESSES (Print names and titles)			
SIGNATURE OF REGISTRAR (Print name and title)			